be prevented. The best explanation for any lack of sensation in the abdominal organs is to be found in the damage done to the fine sensory fibers in the abdominal cavity. These injuries have been demonstrated by various investigators, but only in animals. They can, however, be accepted for the same conditions in men.

An Operative Cure of a Hernia into the Fossa Duodenojejunalis of Treitz.—HELLER (*Archiv f. klin. Chir.*, 1909, xc, 360) reports a case in which a man had been suffering for six months from a chronic intestinal obstruction, and had become very weak and miserable. Vomiting occurred every twelve to twenty-four hours, with a sudden ejection of 1 to 2 liters of a gall-stained watery fluid, but without bad odor. The central parts of the abdomen were distended, the flanks rather sunken. The central distention was in the form of a globular tumor about the size of a man's head, in the region of which peristaltic movements were visible and audible. The diagnosis of a probable tuberculous peritonitis was made, with a kinking of the upper part of the intestine. After a wide opening of the abdominal cavity had been made, there was visible a tumor which had somewhat the appearance of a thick-walled ovarian cyst. The large intestine could not be seen encircling the mass of small intestines. Upon raising the lower pole of the tumor, the lowest coils of the ileum could be seen slowly emerging from a funnel-shaped opening. They were adherent to the margins of the opening, and could not be drawn out. The hernial sac was then split in its whole extent in the median line, when the enormously distended coils pushed out. They were, however, adherent within and were separated with much difficulty. From the duodenojejunal flexure to the cecum the coils were separated from one another, centimeter by centimeter, in order to remove the numerous kinks in them. The stomach was seen to be very much distended, and to be continued with a wide open pylorus over into the duodenum, which was almost as large as the arm. The stomach and pylorus, as well as the enormously distended ileum, were especially adherent to the inner wall of the sac, and kinked. The remaining intestines were also dilated and hypertrophied. At the completion of the separation of the intestines, the patient was in collapse. Two days after operation he again became acutely collapsed. Upon a partial reopening of the abdominal wound, an acute dilatation of the stomach was detected. A Kader fistula was made into the enormously dilated ileum, from which escaped large quantities of gas, but almost no fluid. The patient improved. On the fourth day the fistula had closed. A half year after operation the patient had gained eighteen pounds. Digestion continues without disturbance.

Reduction of an Unreduced Dislocation of the Shoulder by Posterior Arthrotomy.—MADELUNG (*Archiv f. klin. Chir.*, 1909, xc, 1126) in resections of the head of the humerus, employs the Kocher method, which consists of a curved posterior incision with a chiselling off of the spine of the scapula. It gives a free exposure of the joint, the function of the deltoid and the other shoulder muscles remains good, and subluxation of the upper end of the humerus toward the coracoid process is prevented. Madelung employed it in a case of subcoracoid dislocation of the

right shoulder, unreduced seven weeks after the accident. The right arm and hand were apparently paralyzed, although there were no considerable disturbances of sensation. The elbow was rigid in a right-angle position. An attempt to reduce the dislocation under ether was unsuccessful. By the Kocher method the shoulder-joint was exposed and opened. The dislocation was easily and quickly reduced by the use of a strong resection hook, which was aided by a large lever with a spoon-shaped end. The acromion was fastened in position with sutures. Three days after operation passive movements and the use of electricity were begun. The wound was completely healed in seven days, but the symptoms of paralysis disappeared slowly. Ten weeks after operation the patient could elevate his arm to a level with the shoulder. Passive movements in the shoulder were completely free, and he could make a fist. Pronation and supination at the elbow were possible. Active extension, however, was only slight.

Ligation of the Veins in Portal Thrombosis from Appendicitis.—WILMS (*Zentralbl. f. Chir.*, 1909, xxxvi, 1041), in a severe case of appendicitis, ligated the veins passing from the cecum and appendix, with the result that the chills promptly ceased, and good healing followed. The course of the case was as follows: On May 14, a man, forty-two years old, was relieved of a large appendiceal abscess, which had been developing for ten days. He had had two chills at intervals of several days. On the second day after the incision had been made into the abscess, another chill occurred; on the third day three chills with temperatures of 41.1°, 40.8°, 40.3° C., and on the fourth day a chill with a temperature of 40.4°. Two hours later the ligation of the veins was performed, and was soon followed by a normal temperature and healing without further complications. All the cases of suppurative, portal thrombosis which Wilms had previously seen proved fatal, the great danger being development of liver metastases. Early operation for appendicitis has rendered them much less common than formerly. The resection of the cecum and lower end of the ileum may come into question after ligation of the veins. In performing this operation, Wilms passed his finger under the ascending colon, which, with its mesentery and that of the lowest portion of the small intestine, were separated from the posterior abdominal wall. After division of the anterior layer of peritoneum, the vessels came well into view. The small arteries were isolated so that they would not be included in the ligatures. All the veins were then ligated in two bundles. A tampon was placed on the cecum for drainage in case gangrene of the cecum occurred. Not a single chill followed the operation. The operation must be done before liver metastases develop.

The Operative Treatment of Tuberculosis of the Vas Deferens and of the Seminal Vesicles.—CHOLTZOFF (*Ann. de mal. des org. gén.-urin.*, 1909, ii, 1121) says that these organs may be reached by one of three routes—the inguinopelvic, the perineal, and by temporary resection of the sacrum. Twelve cases are reported. When, after castration or epididymectomy, we are convinced that the tuberculous process in the seminal vesicles shows no signs of regression, but remains *in statu quo*